

# THE RHODE ISLAND MEDICAL JOURNAL

The Official Organ of the Rhode Island Medical Society  
Issued Monthly under the direction of the Publication Committee

VOLUME XIX }  
NUMBER 4 } Whole No. 319

PROVIDENCE, R. I., APRIL, 1936

PER YEAR \$2.00  
SINGLE COPY 25 CENTS

## ORIGINAL ARTICLES

### SOCIAL MEDICINE AND THE DOCTOR\*

By ROLAND HAMMOND, M.D.

219 WATERMAN ST., PROVIDENCE, R. I.

*President, Rhode Island Medical Society*

In times of great economic strain and stress, when we are called upon to pay for an orgy of spending, the hardship falls upon those least able to bear the burden. This is especially true in the case of the unfortunate and in cases of illness. Moved by commendable sympathy and zeal, certain sociologists and social workers are proposing such cure-alls as compulsory sickness insurance, advocated as a way to bring adequate medical care to all the people. This scheme has incurred the almost universal condemnation of the medical profession,—the very men who would be called upon to make it effective, and who judge it in the light of their experience.

There is no body of men which is more deeply moved by the spectacle of people in need than the medical profession. Throughout the depression, as well as before, we have offered our services unsparingly in the alleviation of the miseries of those who are unable to pay for medical care, as well as those unable to pay but part of its cost. This is a traditional, an historic obligation of the profession. The physicians of America have met this responsibility within the past five or six years, in a creditable manner, accepting their share of financial sacrifice and responsibility in good spirit.

So well has this emergency been met under the prevailing system of practice, that there has been very little lack of medical care, if the person need-

ing, or his family, will seek it. Physicians do not eject patients from their offices because they do not have cash in hand, nor do clinics close their doors to them. If the patient cannot pay the doctor in full, he pays less; if he has nothing, he is treated without cost or is referred to institutions which care for indigent patients. This is always the case if the patient *seeks* medical care; if he does not, can it be forced on him to good purpose?

But, it is claimed that there is a lack of medical care generally in this country. It is made to look as if the medical profession is withholding from people the services which it is their business to provide. This claim is based largely on the results of periodic medical examination of school children, and on the medical examination of men drafted for war service, and on certain surveys of small population groups. These reveal undoubted cases of poor health, defects which can be remedied, actual disease and medical neglect. Does this justify a belief that a system of compulsory sickness insurance would remedy the situation? It has not done so in any country where this system of medical practice is in vogue. We have no statistics whatever from such studies as these showing that any percentage of the population, desirous of medical care, and seeking it, is unable to obtain it.

We are forced to the conclusion that most of the plans proposed for the relief of low income groups originate with social theorists, salaried altruists and "charity brokers" who are anxious to enlarge the organizations they conduct and increase their personal prestige. Many such groups actually vie with one another to secure a numerical increase in the number of cases handled.

The principle is fallacious and unworthy. We should as reasonably expect the prisons and asylums of the State to compete for inmates.

The abuse of medical charity arouses the indig-

\*Read before the Providence Medical Association, January 6, 1936.

nation of the doctor, since every case of malingering prevents the extension of legitimate aid to a worthy object. The exercise of charity has now become an organized and remunerative industry in the hands of social theorists who hoodwink the government, prey upon the doctors, exploit the poor and weaken or destroy the virile American traits of self respect, resourcefulness and resolution.

Two widely antagonistic forces are struggling for control in America. On one side is the striving of individual initiative, the old pioneer spirit under which we have grown great. On the other hand is the program of regimentation, a conspiracy to have the people subjected to herd ideas, whether advantageous or otherwise.

The doctor is by instinct and training an individualist,—a most essential attribute in the struggle against disease and death, where his skill and experience must always be unhampered by social or political domination.

Regimentation, on the other hand, inhibits all chance of growth in the average mind. It diminishes efficiency in a person whose training requires him to work in congenial surroundings, untrammelled by petty rules. No medical man will be interested to practice for love of his work, research will be inhibited, enthusiasm for progress stunted.

With a full knowledge of the prevailing economic and social conditions, the medical profession has been striving to correct social evils, accommodate its work to the changing face of society and adapt its practice to modern conditions of living and industry. New forms of medical procedure are being tested in nearly all the states and unusual plans for medical service are being introduced. Just as our present system of practice and our code of ethics have been built up through many centuries of trial and error, so we realize that we must proceed slowly and by careful experimentation, in advocating changes in our methods, partly to accommodate a temporary economic condition, and partly to allow for a gradual evolution in our civilization.

These methods are too slow, however, for the social theorists, who want the world revamped

according to their own visionary fancies. The recent attempt to foist their ideas upon the public in the report of the Committee on the Cost of Medical Care was a failure because they did not appreciate the psychology of the situation. They did not realize that the public demands as an inalienable right, the privilege of choosing their own medical advisor. They will not necessarily be forced to patronize a clinic or other form of group practice.

Other forces are at work, and various committees, funds, foundations, corporations and societies are ready, at the first opportunity, to take up the fight for the socialization of medicine. Except for the strenuous efforts of the American Medical Association, such legislation would have been passed at the last session of Congress, since it was introduced and had powerful backing. We may expect a further onslaught in the session just opening at Washington.

The immediate goal which the salaried altruists hope to attain in medicine is socialization. This is a menace both to medicine and to the public. In order to accomplish their aims a large lay organization must be set up, which will control the practice of medicine.

The important question, from the point of view of the individual physician, is, what can you and I do to aid the forces of organized medicine in this fight? It is of vital importance to every one of us, because if the opposition is successful in passing legislation which is inimical to the best interests of the medical profession and the public, it will inevitably result in changed conditions of practice. Socialized medical practice will be both unsatisfactory and unremunerative. A body of men which has hitherto worked unfettered by irritating rules and regulations, will find itself at the mercy of a Federal and state bureaucracy, its methods of treatment held up to question, its very probity the subject of investigation.

It is too late to say "Oh, this can never happen." The danger is already present, and unless we are willing to fight for what is right and just we shall be the losers.

We must support the forces of organized medi-

cine which are waging the battle. A strong, active, well organized district society is the keystone of our strength. There should be a larger membership in the State Society. It is a sad truth, that there are about 125 members in this district Society who have not availed themselves of the opportunity to join the Rhode Island Medical Society. Such action would not only strengthen our defensive forces, but would offer distinct privileges to every prospective member. The advantages are many and obvious, and it seems unnecessary to call attention to them. The privilege of attending the meetings, the use of the library, and the ability to obtain liability insurance at a reduced rate under the Rhode Island Medical Society arrangement, are a few of the material benefits to be obtained. More important than all of these, however, is the responsibility which every member of a district society should feel, that he must take his part in this movement to protect his rights, and those of the public, that he should put his shoulder to the wheel and help push. The lone wolf has no standing in any pack. The power of an organized body is so evident that it deserves no mention of specific cases.

It is probable that the best solution of this vexing problem, lies in the education of the general public and legislators by the medical profession. Most of us fail to realize the great respect in which the public holds our opinions in matters affecting their health and welfare. Every physician, in his daily rounds should drop a hint or argue the question, when the subject of social security and medical legislation is under discussion. The family physician of a legislator will have great weight in helping to mould the statesman's opinions in the right direction.

The question of State medicine will be brought forcibly to the attention of the youth of this country, as well as their families, during the present school term. Eight thousand high schools throughout the country are preparing to debate the question of State medicine. The resolution is phrased as follows:

"RESOLVED, That the several states should enact legislation providing for a system of complete medical service available to all citizens at public expense."

This means that throughout the country, in secondary schools and in associated circles, the question will be under continual discussion this winter. It is estimated that audiences will total a million persons. Debaters are supplied with plenty of material, affirmative and negative, from well recognized sources. Requests for information to be used in this debate have already been received by your President, and similar appeals are coming to hand in other states.

What further proof is necessary that the subject of State medicine is not a visionary bogey? It is no longer in the offing. It is already upon us. Every physician must familiarize himself at once with the arguments pro and con of this question, since he will inevitably be subjected to a grilling by the young people during the course of family visits.

Intelligent study and discussion of the subject will throw much light on many phases of the matter. If we are to desert the system of individual practice which has made medical care in America the best obtainable anywhere in the world, and accept the principles of socialism in guarding the health and lives of the public, it should not be done until after critical analysis by the thinking people of the country has disclosed, not only the advantages which an ideal state promises to bring, but also the cruel realities which are integral in bureaucratic regimentation.

It is my firm conviction that if we are willing to use to proper advantage our great power and influence with the public, and are able to lend our individual efforts to aid the fight which organized medicine is making in our behalf, we shall see this question settled in a right and proper manner. The correct solution of this problem will not only vindicate the traditions of medical practice throughout the centuries, but it augurs the dawn of a more splendid co-operation between the medical profession, the general public, and the State and Federal governments.

Acknowledgment is made to the following splendid addresses on this subject:

"The Social Security Act and the Doctors," by Charles B. Reed, M.D., President of the Illinois State Medical Society.

"Medicine and Men," by Frederic E. Sondern, M.D., President of the Medical Society of the State of New York.

# THE RHODE ISLAND MEDICAL JOURNAL

Owned and Published by the Rhode Island Medical Society  
Issued Monthly under the direction of the Publication Committee, 106 Francis Street

FREDERICK N. BROWN, M.D., *Editor*  
309 Olney Street, Providence, R. I.  
ALBERT H. MILLER, M.D., *Asst. Editor*  
28 Everett Ave., Providence, R. I.

CREIGHTON W. SKELTON, M.D., *Business Manager*

WILLIAM P. BUFFUM, M.D.  
ALEX M. BURGESS, M.D.  
W. LOUIS CHAPMAN, M.D.  
G. G. DUPRE, M.D.  
THAD. A. KROLICKI, M.D.  
EDW. V. MURPHY, M.D.  
MALFORD W. THEWLIS, M.D.  
GUY W. WELLS, M.D.  
GEORGE L. YOUNG, M.D.

*Contributing  
Editors*

*Committee on Publication*

LUCIUS C. KINGMAN, M.D., *Chairman*  
HARRY C. MESSINGER, M.D.  
CHARLES S. CHRISTIE, M.D.  
*President and Secretary, ex-officiis*

Advertising matter must be received by the 10th of the month preceding date of issue.

Advertising rates furnished upon application to the business manager, CREIGHTON W. SKELTON, M.D., 106 Francis St., Providence, R. I.  
Reprints will be furnished at the following prices, providing a request for same is made at time proof is returned: 100, 4 pages without covers, \$6.00; each additional 100, \$1.00; 100, 8 pages, without covers, \$7.50; each additional 100, \$2.80; 100, with covers, \$12.00; each additional 100, \$4.80; 100, 16 pages, without covers, \$10.50; each additional 100, \$3.00; 100, with covers, \$16.00; each additional 100, \$5.50.

SUBSCRIPTION PRICE, \$2.00 PER ANNUM, SINGLE COPIES, 25 CENTS.

Entered at Providence, R. I., Post Office as Second-class Matter.

## RHODE ISLAND MEDICAL SOCIETY

Meets the first Thursday in September, December, March and June

ROLAND HAMMOND	<i>President</i>	Providence
JOHN E. DONLEY	<i>1st Vice-President</i>	Providence
WALTER C. ROCHELEAU	<i>2nd Vice-President</i>	Woonsocket
J. W. LEECH	<i>Secretary</i>	Providence
J. E. MOWRY	<i>Treasurer</i>	Providence

### DISTRICT SOCIETIES

#### KENT

Meets the second Thursday in each month

ROCCO ABBATE	<i>President</i>	Lakewood
GEORGE L. YOUNG	<i>Secretary</i>	East Greenwich

#### NEWPORT

Meets the second Thursday in each month

HORACE P. BECK	<i>President</i>	Newport
ALFRED M. TARTAGLINO	<i>Secretary</i>	Newport

**R. I. Ophthalmological and Otological Society**—2d Thursday—October, December, February, April and Annual at call of President.  
Dr. N. A. Bolotow, President; Dr. Gordon J. McCurdy, Secretary

**The R. I. Medico-Legal Society**—Last Thursday—January, April, June and October, Benjamin F. Tefft, M.D., President; Dr. Jacob S. Kelley, Secretary-Treasurer.

PAWTUCKET		
Meets the third Thursday in each month excepting July and August		
WALTER J. DUFRESNE	<i>President</i>	Pawtucket
THAD A. KROLICKI	<i>Secretary</i>	Pawtucket

PROVIDENCE		
Meets the first Monday in each month excepting July, August and September		
WILLIAM S. STREKER	<i>President</i>	Providence
HERMAN A. LAWSON	<i>Secretary</i>	Providence

WASHINGTON		
Meets the second Wednesday in January, April, July and October		
JOHN E. RUISE	<i>President</i>	Westerly
JOHN CHAMPLIN, JR.	<i>Secretary</i>	Westerly

WOONSOCKET		
Meets the second Thursday in each month excepting July and August		
HENRI GAUTHIER	<i>President</i>	Woonsocket
G. G. DUPRE	<i>Secretary</i>	Woonsocket

## EDITORIALS

### THE OCHSNER-SHERREN (DELAYED) TREATMENT OF ACUTE APPENDICITIS

Many observers have followed the delayed treatment of appendicitis in some cases with excellent results. Hamilton Bailey (*The British Medical Journal*, 1: 140, 1930) states that as the diagnosis of acute appendicitis is made and when the history of attack is under 48 hours' duration, immediate operation is nearly always advised. However, as the diagnosis of acute appendicitis is made and the

history is over 50 hours' duration, one should ask oneself the question, "Is there any reason why this appendix should be removed at once?" The answer by one treated in the delayed treatment is, "It is safer to postpone operation for the time being unless (1) hyperesthesia is present; provided that the other signs are consistent, this may be taken as good evidence that the appendix is still unperforated. (2) Age under five years. (3) The diagnosis cannot be made between acute appendicitis and some other intra-abdominal catastrophe normally requiring immediate operation, especially perforated diverticulitis and perforated duodenal



ulcer. (4) General peritonitis has supervened. Only cases which have obvious general as opposed to pelvic peritonitis are excepted. (5) The recent ingestion of a powerful purgative may be a justifiable indication.

Bailey feels that the key to lowering the total mortality of appendicitis is to be found in the standardization of the type of case to be treated by immediate operation together with the proper selection of patients for the Ochsner-Sherren technique.

In these delayed treatments the appendix is removed in due course. Bailey feels that the advantages of the delayed treatment are that subphrenic abscess is almost unknown; pylephlebitis does not occur; intestinal obstruction is very much rarer than after immediate operation; there is no hardship to the patient.

More recent reports show that this form of treatment is being used in various parts of England with as good results as those reported at earlier dates. These observers feel that this is an excellent method, in selected cases, to reduce the mortality of this disease.

#### REPORT OF THE 1935 EPIDEMIC OF ACUTE ANTERIOR POLIOMYELITIS\*

By KALEI K. GREGORY, M.D.

DENNETT L. RICHARDSON, M.D., EDWARD J. WEST, M.D.,  
RAYMOND E. STEVENS, M.D.

*Collaborators*

During the epidemic of acute anterior poliomyelitis that has just passed, 228 patients were admitted to the Charles V. Chapin Hospital of which 126 were from Providence and 102 from cities and towns in Rhode Island and nearby Massachusetts. This number includes a fatal case in January. The first case of the epidemic admitted to the hospital was on July 5. The total number of cases admitted in July was 7, in August 83, in September 96, in October 29, and in November 12. The peak of admissions was during the week ending August 31, with 43 cases. For eighteen days, from September 22 to October 10, there were 100 or more cases of acute poliomyelitis in the hospital. The largest number of cases in the hospital at any one time was 115 on October 3. It is interesting to note that during the peak of the epidemic the number of cases of other infectious diseases usually admitted to the hospital at this time dropped to a very small number.

\*Read before the Providence Medical Association, December 2d, 1935.

(Continued on page 48)

#### THE JOURNAL'S COLUMN

To insure prompt attention, the readers of this JOURNAL are advised: That matters pertaining to advertising, mailing and accounts should be addressed the Business Manager, Dr. C. W. Skelton, 106 Francis Street, Providence, R. I.

Other matters, books for review, notices, manuscript, letters, reports of meetings, and all affairs of literary nature should be addressed to the Editor, Dr. Frederick N. Brown, 309 Olney Street, Providence, R. I.

#### AS TO BOOK REVIEWS

Books received for review are the property of the Rhode Island Medical Society.

Inasmuch as it is a compliment to be asked to review a scientific book, it is to be hoped in courtesy to the publishers that the review may be finished within a period of thirty days, the book sent to the Society's library and review to the Editor.

Should sixty days elapse before receipt of book (and review) the matter must be referred to the discretionary action of the Society in the recovery of its property.

"Letters to the Editor" are considered to be the personal expression of the writer's opinion upon the subject of which he writes.

The RHODE ISLAND MEDICAL JOURNAL disclaims any responsibility for these opinions and is not to be held accountable for any sentiment therein expressed or implied.

#### BOOKS RECEIVED FOR REVIEW

##### A TEXTBOOK OF SURGERY:

By American Authors. Edited by Frederick Christopher, B.S., M.D., F.A.C.S., Associate Professor of Surgery at Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital, 1608 pages with 1394 illustrations on 730 figures. Philadelphia and London: W. B. Saunders Company, 1936. Cloth, \$10.00 net.

##### EXAMINATION OF THE PATIENT AND SYMPTOMATIC DIAGNOSIS:

By John Watts Murray, M.D.; with 274 illustrations. Second Edition. St. Louis, The C. V. Mosby Company, 1936. Price, \$10.00.

##### ABORTION, SPONTANEOUS AND INDUCED: MEDICAL AND SOCIAL ASPECTS

By Frederick J. Taussig, M.D., F.A.C.S., Professor of Clinical Obstetrics and Clinical Gynecol-

ogy, Washington University School of Medicine, St. Louis. Illustrated. This volume is one of a series sponsored by the National Committee on Maternal Health, Inc. St. Louis, The C. V. Mosby Company, 1936. Price, \$7.50.

#### SYNOPSIS OF CLINICAL LABORATORY METHODS:

By W. E. Bray, B.A., M.D., Professor of Clinical Pathology, University of Virginia; Director of Clinical Laboratories, University of Virginia Hospital. Thirty-two illustrations. Eleven color plates. St. Louis, The C. V. Mosby Company, 1936. Price, \$3.75.

#### MEDICAL PAPERS DEDICATED TO HENRY ASBURY CHRISTIAN, PHYSICIAN AND SURGEON:

From his present and past associates and house officers at the Peter Bent Brigham Hospital, Boston, Mass. In honor of his sixtieth birthday, February 17, 1936. The Williams & Wilkins Company, William Wood & Company, Baltimore, 1936.

### REPORT OF THE 1935 EPIDEMIC OF ACUTE ANTERIOR POLIOMYELITIS

(Continued from page 47)

This has been the second major epidemic of acute anterior poliomyelitis in this vicinity during the past four years and the largest in the history of the State. The first was in the summer and fall of 1931 with 129 admissions to the hospital. There were 10 deaths, a fatality rate of 7.8%.<sup>1</sup>

The age distribution of the cases in this present epidemic is as follows:

Under 1 year.....	7	10-14 years .....	36
1-4 years .....	79	15-19 years .....	10
5-9 years .....	81	Adults .....	14

The oldest patient in the present group of admissions was 52 years, and the youngest 30 days old.

There have been 16 deaths in the present series of cases, a fatality rate of 7.1%, which is slightly lower than the 1931 epidemic. The first death was an isolated case in January. There was no death in July, there were 8 deaths in August, 5 in September, 1 in October, and 1 in November.

The age distribution of the deaths is as follows:

1 death at 2 years	1 death at 13 years
2 deaths at 6 years	1 death at 15 years
5 deaths at 7 years	1 death at 17 years
1 death at 8 years	1 death at 27 years
1 death at 9 years	1 death at 29 years
1 death at 12 years	

Five of the deaths were of the Landry's or ascending type of the disease. Ten patients died of primary bulbar paralysis. One, an adult, with extensive

paralysis involving the legs, arms, urinary bladder, bowels, diaphragm, and the respiratory muscles, died 39 days after admission of a secondary infection, probably pneumonia. This patient had been in the respirator continuously since admission.

Acute anterior poliomyelitis is a communicable disease. The virus is carried about in the nose and throat of the patient and carrier. The incidence of the clinical type of the disease is low but the communicability is high. There is evidence to show that hundreds and perhaps thousands of the inhabitants in a given community are either carriers or have had the disease in a very mild or abortive form during an epidemic. It is when one believes in this idea that the apparent mysterious behavior of poliomyelitis, current among the lay population as well as among many physicians, becomes clear. This idea is no longer a theory or a speculation. There is enough proof on hand now to make it a fact. We do not make a mystery of the behavior of acute epidemic cerebrospinal meningitis or of encephalitis lethargica, and yet these two diseases behave very much the same way as anterior poliomyelitis. Unfortunately, we have no practical means at present of determining infection with the poliomyelitis virus before the invasion of the central nervous system and the appearance of clinical signs.

In the epidemic of 1931, two student nurses developed infantile paralysis at the Charles V. Chapin Hospital. During the present epidemic, no one has contracted the disease at the hospital. But a warning has come from California. During an epidemic of anterior poliomyelitis last year (1934) as reported from the Los Angeles County Hospital,<sup>2</sup> 16, or 10% of the 160 physicians living in the hospital developed infantile paralysis; 27, or 36% of the 75 nurses working in the communicable disease unit and living in the hospital contracted the disease. Those living outside of the hospital had a lower attack rate of the disease. This astounding report is a warning to the physicians and health officers in this country. What this means for the future is speculative. This mild, well-mannered pet may grow up to be a very vicious creature.

Seventy of the 228 cases had no paralysis on admission to the hospital. Of these, 18 subsequently developed paralysis of varying degrees and 2 died. Fifty-two remained unaffected throughout their stay in the hospital. It was interesting to note that toward the end of the outbreak, more and more of the non-paralytic type of the disease were admitted. Of the first half, or 114 cases admitted to the hos-

pital, 28 had no paralysis, and of the second half (114) of admissions, 42 were without paralysis. The wide publicity through the newspapers and the radio may have been a factor in bringing patients to the physician in the early stages of the disease, but we believe the chief factor is that the severity of the disease decreases as the epidemic wanes. This is true of epidemics of other infectious diseases. In the 1931 epidemic of poliomyelitis, 54 of the 129 cases were admitted in the non-paralytic stage, 5 developed paralysis while in the hospital, and 49 were discharged without paralysis.<sup>1</sup>

An analysis of the symptoms and physical findings of the cases in this present outbreak has been very interesting. Almost every conceivable type of this disease described in the literature was seen.

In a great number of cases, the earliest symptoms are evidences of a mild upper respiratory infection, invariably a slight sore throat, and fever. In a day or two, the patient seems better and is allowed up. About the second or third day after this apparent invasive period, symptoms of headache, fever, irritability, vomiting, pain in the neck and back, and sometimes pain in the extremities appear. These recurrent prodromal symptoms have been described as the dromedary (a term now considered erroneous) or diaphasic form of onset of the disease.<sup>3,4</sup> 46% of our admissions gave this diaphasic form of onset before paralysis which appeared usually from one to three days after the second phase. A few patients developed paralysis suddenly without having any prodromal symptoms whatsoever. The rest of the cases, approximately 50%, gave a history of preliminary illness before clinical symptoms or paralysis appeared, anywhere from one to seven days. Constipation, rather than diarrhea, is present in 98% of our cases. One of the most noticeable symptoms in this outbreak is somnolence. The patient can be easily aroused but when left alone falls asleep again. The paralysis is completed usually within three days, occasionally longer, especially in adult patients.

The diagnosis of acute anterior poliomyelitis in its earliest stages in the inter-epidemic period is difficult except to the experienced physician. The appearance of flaccid paralysis of course is a very conclusive sign. The diagnosis is relatively easier during an epidemic. A good history of the patient is essential. When a child presents symptoms of an acute infection accompanied by headache, vomiting, irritability, pain or stiffness in the neck and back, constipation or diarrhea, perhaps pain or tenderness

in the extremities, and with a history of slight illness a few days previous, then poliomyelitis should be suspected especially during an epidemic of the disease.

The physical findings in the average case are quite characteristic. The patient lies quietly, usually does not appear sick, but does not want to be disturbed. The neck is moderately stiff when the head is flexed on the chest and the patient complains of pain in the upper back or in the lumbar region. The spine is straight and stiff when anterior flexion on the thigh is attempted. When the sitting position is attained, the patient braces himself with both arms to keep from falling back. This posture, with the stiff back, the extended arms, and the bed, forms the so-called "tripod sign." If then the child is asked to bend forward and touch his knee with his chin, the answer is "I can't." This is the so-called "audible sign." The reflexes are at first exaggerated and then if the paralysis is to follow, become diminished and finally lost. During this epidemic these findings have been lacking in about 15% of the cases, thus making the diagnosis difficult. Fortunately at this stage of the disease pathological changes in the cerebrospinal fluid have already taken place in the great majority of patients to aid in the diagnosis.

Examination of the spinal fluid in our cases invariably shows a slight increase in globulin as tested by Pandy's reagent. The cell counts range from 10 to 1700 per cubic m.m. In the majority of cases the cell count varied between 20 and 200. Two patients in our group of cases showed negative cell count, but the diagnosis was confirmed in one patient by a marked weakness in one leg, and in the other by a paralysis of the wrists, hands, arms, and legs. The differential count in our experience shows a high percentage of lymphocytes, and only occasionally a high percentage of polymorphonuclear cells. The sugar and chloride content are within the normal limits. The leucocyte count of the blood is of little help in the diagnosis of this disease. The count may be normal or very high.

A very careful examination is necessary in order to detect weakness of muscle and this is not always easy in small children. In addition to the usual distribution of paralysis in the extremities and trunk, there has been an unusually large number of paresis of the urinary bladder with resultant retention of urine. We had 20 patients with this complaint. Older patients as well as very young children were affected. The retention for the most part was of

short duration, lasting usually from two to five days but in four adult patients it was necessary to insert an indwelling catheter for two to three weeks. All except one, a fatal case, recovered the normal use of the bladder. Sensory disturbances with marked hyperesthesia were observed in a few patients. These patients could not tolerate even the touch of bedclothing. One patient had acute arthritis of the ankles and knees along with paralysis involving both legs. A most interesting observation in this group of cases was the recurrence of acute symptoms and the extension of paralysis in one case when to all appearances the patient was well along in the convalescent period. Patients with relapses or exacerbations of this disease have been reported in the literature, but this was the first case we had seen. The explanation of this clinical variance is not obvious.

The distribution and the degree of paralysis in our cases was so diversified that it could not be tabulated in a paper of this sort. Perhaps the most unusual finding in this outbreak is the large number of patients showing involvement of the higher centres of the central nervous system. Forty-two of the 228 admissions showed evidence of injury to the vital centres. Fifteen of this group died, 5 with the ascending type of paralysis and 10 with primary bulbar involvement. Twenty-seven survived and some were subsequently discharged with little or no residual paralysis attributable to destruction of the cranial nerve ganglion. Somnolence was very marked in these types of cases. Several exhibited such marked drowsiness that they could not be distinguished from encephalitis lethargica. Subsequent events, however, confirmed the diagnosis of acute anterior poliomyelitis. The duration of the somnolence was from seven to ten days. One patient on recovering became maniacal and had to be transferred to the psychopathic ward.

Paralysis due to injury of nerve centres in the pons and medulla occurs most frequently in these cases. Paralysis of the glossopharyngeal nerve gives a nasal tone to the voice, and causes difficulty in swallowing. If given fluid to drink the patient is unable to swallow or spit it out, the fluid coming out through the nostrils. The patient becomes cyanotic and greatly frightened. Large quantity of mucus collects in the throat, and in untreated cases the mucus gravitates into the trachea and bronchi. This is usually a fatal sign. Paralysis of the facial nerve, usually on one side, may manifest its central origin by the distribution of paralysis or in some

cases completely as in Bell' Palsy. The abducens nerve is the next frequently affected causing an internal strabismus usually on one side. The nerve which innervates the tongue, the hypoglossus, is also most commonly injured, causing the tongue to protrude toward the affected side. The third cranial nerve, the oculomotor, is likewise affected and results in ptosis of the eye-lid and loss of convergence, also disturbance of ocular rotation. In fatal cases the vagus nerves and the respiratory centre are involved, the latter being characterized by the Cheyne-Stokes type of respiration. Any or all of these nerves may be affected. An extensive involvement usually ends fatally. An unusual type of this disease was seen with symptoms of bulbar paralysis occurring first followed by paralysis of the shoulders and arm. This has been described as the descending type of paralysis. A few patients show, in addition to the marked drowsiness, both fine and coarse tremors of the arms and hands. Two patients in particular showed choreiform movements of the upper extremities and dizziness on sitting up suggesting involvement of the cerebellum. One of these patients, on recovering from the somnolence, could not speak for several days but once he started talking he could not be stopped. He eventually recovered without any obvious residual paralysis.

The treatment of anterior poliomyelitis in the acute stage is, at best, unsatisfactory at the present time. The one means upon which great hope was based—the human convalescent serum or blood—has not shown conclusively good results. However, individual reports from everywhere in this country as well as from abroad show optimism. Our own report of the 1931 epidemic was very favorable on the use of the human serum but a compilation of all these reports showed anything but good results.<sup>5</sup> But however disappointing this may be, the use of the human convalescent serum should not be discouraged. Wesselhoeft, in an excellent paper<sup>6</sup> on this subject, reminded us of the fact that the results of the first serious clinically controlled hospital study of diphtheria antitoxin collected by Bingel in an elaborate protocol in 1918 were unfavorable to antitoxin treatment but no one now doubts the efficiency of this remarkable discovery.

There are several factors which of necessity influence the efficiency of the human convalescent serum in acute poliomyelitis. We will discuss only one of these which to our mind is of prime importance and that is the stage of the disease at the time



of treatment. We do not mean the stage of the disease clinically, but the stage of the disease pathologically. Investigators working with monkeys assure us that examinations of the spinal cord of these animals infected with the poliomyelitis virus and killed in the preparalytic stage of the disease show advanced pathological changes without the animals showing any clinical findings aside from the primary symptom<sup>6</sup> which means that even if serum is given in the clinical preparalytic stage the damage has already been done, hence the indifferent results. This is not surprising when one remembers the experience with human serum therapy in other virus infecting diseases such as in measles. This very efficient human convalescent serum becomes less effective when given late in the incubation period and useless when given after symptoms of measles appear. This leaves us with the only one alternative, that of giving the serum either at the very earliest onset of illness or even before this. Of course the difficulty in diagnosis comes in, for there is no practical means of determining whether the slight upper respiratory complaint and the slight headache and sore throat are symptoms of acute poliomyelitis or of a common ordinary cold. But if one desires and uses the serum at this stage, there would be no harm done and perhaps a great deal may be profited by it. In other words, the human convalescent serum may logically be used as a means of developing passive immunity for protection during an epidemic unless we can find something better. We are again reminded of the California epidemic. At the Los Angeles County Hospital<sup>2</sup> prophylactic serum was given to all employees who elected to take it. Twenty cubic centimeters of either convalescent pooled or normal pooled serum was given and repeated every two weeks. Of the 3,986 employees in the entire hospital, 892 were given the prophylactic human serum, and 61 or 6.8% developed poliomyelitis. 3,094 employees received no serum; of these 54 or 1.7% came down with the disease. An analysis of the 115 who developed infantile paralysis shows that 61 or 52.6% had received serum and 54 or 47.4% had not. The unusually high rate of communicability of this epidemic gave an excellent opportunity to test out the value of human serum as a prophylaxis against anterior poliomyelitis. The results seem to be discouraging, but this should not be considered conclusive until more experience with this manner of treatment is obtained.

At the beginning of the epidemic of poliomyelitis

in July, we took a non-committant attitude toward the use of convalescent human serum for treatment. Of the 68 cases who were admitted without paralysis, 26 were given convalescent human serum in doses of 40 to 80 cc. intravenously; this being now considered the method of choice. Sixteen or 61.5% of the treated cases were discharged without paralysis, and 10 or 38.5% with varying degrees of paralysis. Thirty-four or 81% of the 42 patients who did not receive serum went home without paralysis and 8 or 19% developed paralysis. Two of the patients who received serum developed bulbar paralysis and died.

The treatment of the paralytic cases consisted of symptomatic medication. An effort was made to keep the extremities warm and comfortable, to keep the bedclothing off the toes, and to keep the child quiet. The orthopedic surgeon was called in early in the outbreak and splints and frames were supplied. This helped to prevent contracture and weakening of the muscles from overuse. It is our belief that early light massage, passive motion of the joints, and very limited muscle re-education should be begun; not of course while there is much tenderness, although we have observed tenderness to disappear under this treatment. A trained masseuse was engaged early in September to work with the orthopedic surgeon.

With the use of the respirator it has been possible to save several lives. In the bulbar cases the respirator has been of little value. The ideal case for the respirator is one in which the respiratory muscles are paralyzed. After several weeks these muscles recover sufficiently to allow the patient to breathe without aid. These patients should be kept in the respirator for a long time because they are very susceptible to pulmonary infection. There have been six cases in which the use of the respirator has been a life saving measure.

Patients with extensive bulbar paralysis invariably died. Ten out of the sixteen deaths in our series were due to primary bulbar paralysis. The use of suction, postural drainage, and atropine was helpful but it did not save the patients in the majority of cases. Oxygen was used to relieve the cyanosis. These patients usually die within 48 hours from the time mucus collects in the throat and paralysis of the glossopharyngeal nerve. Naturally we felt helpless. Then it occurred to us that if we could by some means keep these patients alive 24 or 48 hours longer or until the height of the acute stage and edema of the medulla had subsided, they might live.

With this in mind, we began in earnest to reduce the edema by the dehydration process. We were well aware of the fact that we could not save those in whom the nerve centres were actually destroyed by the disease process even if we could relieve the edema of the brain. We anticipated failures. However, we felt that if we could save one patient, we would consider the effort repaid. It may be said here that the use of dehydrating substances for relieving edema in the brain is not a new thing. We decided to use 50 cc. of 50% glucose intravenously every 4 or 6 hours; and the intramuscular injection of 2 cc. of 50% magnesium sulphate every 2 hours for six doses, this to be repeated for another course of six doses as the case might be. This plan was carried out on two patients who were admitted at about the same time. These two cases were extremely sick and judging from our past experience were doomed to die. Nothing was given by mouth and intravenous normal saline with 10% glucose was given to supply fluid. We felt that the muscles of the throat needed just as much rest in the acute stage as any similarly affected muscle in other parts of the body. After the acute stage had passed, usually in 24 or 48 hours, feeding through a nasal tube was given until the patient could swallow without choking. We were rewarded for our efforts with recovery of the two patients. This proved to us our belief that a goodly number of these cases die because of the edema in the medulla rather than the destruction of the nerve cells. Furthermore these two patients recovered completely except for a persistent nasal twang. Twelve other cases were treated similarly, making a total of fourteen. Seven of these were of the primary type of bulbar paralysis, and were seriously sick. Seven others were not so seriously ill and might have survived anyway but were given the benefit of the doubt and also received the dehydrating treatment. Three of the seven seriously sick died and four survived. All seven of the less sick lived with the exception of one who died 39 days later of secondary infection, probably pneumonia. This number of cases treated in this way is very small upon which to draw any definite conclusion but we feel that it should be given a good trial.

The total number of patients admitted to the hospital with the provisional diagnosis of acute anterior poliomyelitis was 326. The diagnosis was confirmed in 228 cases and not confirmed in 98.

These 98 cases were variously diagnosed as follows:

Nasopharyngitis .....	18	Rheumatic fever .....	3
Acute tonsillitis .....	10	Trauma .....	3
Acute pharyngitis .....	7	Bell's Palsy .....	2
Acute influenza .....	6	Scarlet fever .....	2
Osteomyelitis .....	3	Hysteria, etc. ....	1
Tuberculous meningitis.....	3		

Sixteen were discharged without a diagnosis and four as having no disease. Twenty-nine different diagnoses were made. The majority of these admissions manifested upper respiratory infections which were, with the exception of five, of very mild nature. These cases, thirty-five in number, together with the sixteen in whom no diagnosis was possible, and the six influenza cases, may have been in reality the sub-clinical or abortive type of acute anterior poliomyelitis.

#### Summary

From January 1st to November 30th, 228 cases of acute anterior poliomyelitis were cared for at the Charles V. Chapin Hospital. Sixteen of the cases died, a fatality rate of 7.1%. Seventy patients were admitted in the preparalytic stage of the disease, 28 developed paralysis, and 59 were discharged without paralysis.

The diaphasic form of the preliminary symptoms of poliomyelitis was a prominent feature in this epidemic. Vomiting and constipation were the chief gastro-intestinal complaints. Somnolence was more marked than usual. Paresis of the urinary bladder with resultant retention of urine was frequent.

A wide variety of clinical types of the disease was seen. Involvement of the higher centres of the central nervous system was frequent. Primary bulbar paralysis accounted for ten of the deaths.

The number of cases treated with the convalescent human serum was too small to be of any significance. A dehydration method of relieving edema of the brain in the encephalitic and bulbar types of the disease showed apparent good results.

#### REFERENCES

1. D. L. Richardson, M.D., and E. J. West, M.D. Rhode Island Medical Journal. Vol. XV, No. 6, p. 100, June, 1932.
2. John E. Kessell, Anson S. Hoyt, and Roy T. Fisk. American Journal of Public Health, Vol. 24, No. 12, 1215-1223.
3. Maurice Brodie and S. Bernard Wortis. Archives of Neurology and Psychiatry, 32: 1159, December, 1934.
4. S. D. Kramer, M.D. Rhode Island Medical Journal, Vol. XIV, No. 5, 69-73, May, 1931.
5. Conrad Wesselhoeft, M.D. The Journal of Pediatrics, Vol. III, No. 2, p. 330, August, 1933.
6. Hurst, cited by Boyd. The Pathology of Internal Diseases, Lea & Febiger, p. 751, 1932.

# SOCIETIES

## THE RHODE ISLAND MEDICAL SOCIETY COUNCIL MEETING

February 19, 1936

The regular quarterly meeting of the Council was held February 19, 1936, at the Medical Library, and was called to order at 4:30 P. M. by the President, Dr. Roland Hammond.

A communication from the California Medical Association objecting to the editor of the Journal of the A. M. A. with reference to a syndicated column in the newspaper was read by the secretary, and it was voted to lay the matter on the table.

The following communication from the Committee on Medical Economics was read: "At a meeting of the Committee on Medical Economics January 3rd, 1936, at 4:50 P. M. at the Medical Library the following motion was adopted:

"This committee recommends to the Council of the Rhode Island Medical Society that all members of District Societies are automatically members of the State Society and that the treasurer of each District Society shall remit to the State Society \$10.00 yearly for each member enrolled to the District Society."

It was the general consensus of the Councillors that such action should be initiated through the District Society as being a unit on which organized medicine is founded, and that the R. I. Medical Society did not wish to appear in the role of coercing the District Society.

It was moved and seconded that the secretary be instructed to communicate this resolution to the various District Societies for their consideration and such action as they determine fit. So voted.

The question of physicians maintaining their membership in the R. I. Medical Society after lapsing of their membership in their District Society has occurred, was discussed. The secretary pointed out that this is very likely to occur by reason of the failure of the District Societies' secretaries to notify the secretary of the R. I. Medical Society of District members who have been dropped or who have resigned from membership in the District Society. He pointed out that it was only by the closest co-operation between the secretary of the District Society and the secretary of the R. I. Medical Society that the status of the Fellows of the R. I. Medical Society with refer-

ence to their District Society can be brought to his knowledge.

It was also voted that this matter be brought to the attention of the Committee on Change in By-Laws.

Adjourned.

Respectfully submitted,

J. W. LEECH, M.D.,  
Secretary.

## HOUSE OF DELEGATES

The regular quarterly meeting of the House of Delegates was held February 19, 1936, at the Medical Library and was called to order at 5 P. M. by the President, Dr. Roland Hammond.

The minutes of the meeting of the Council held just immediately preceding this meeting were presented orally by the secretary.

A letter from Dr. Frank W. Dimmitt, chairman of the Committee to Consider the Situation of the Hard-of-Hearing School Children, of the Providence Medical Association, suggesting that a committee be appointed from the R. I. Medical Society for the purpose of improving the condition of the deafened children was read by the secretary as follows: "About two months ago the Providence Medical Association appointed a committee, of which I am chairman, to consider the situation of the hard-of-hearing children in the schools. We have gone into the matter and are making a report to the Providence Association. I do not know how much is being done in any other sections of the state in regard to this problem, but it seems to us that the R. I. Society might interest itself in the matter. Perhaps a committee might be appointed to get in touch with the various educational units throughout the state and furnish them with some information as to what can and should be done to improve the lot of children handicapped by hearing difficulties.

FRANK W. DIMMITT, *Chairman.*"

A motion was made and seconded that a committee be appointed by the President for this purpose. So voted.

The following communication of the Committee on Medical Economics was presented:

"At a meeting of the Committee on Medical Economics January 3rd, 1936, at 4:50 P. M. at the Medical Library the following motion was adopted:

"At the request of the Department of Labor this committee recommends to the Rhode Is-

land Medical Society that a committee be appointed by the President of not less than three nor more than five to act as an advisory committee to the Director of Labor to be known as the Committee on Workman's Compensation Act.'"

On motion of Dr. Kingman and duly seconded, it was voted that a committee of not less than three and no more than five be appointed, to be known as the Advisory Committee of the Workman's Compensation Act, by the President. Committee appointed: Dr. W. A. Mahoney, Dr. H. E. Harris, Dr. J. W. Leech.

On motion of Dr. Kingman, duly seconded, it was voted that the President, Secretary, and one member of the House of Delegates not an officer of the Society be appointed by the President as a Nominating Committee to put in nominations for officers and members of the Standing Committees for the ensuing year at the meeting of the House of Delegates preceding the annual meeting of the R. I. Medical Society. Committee appointed: Dr. R. Hammond, President, Dr. J. W. Leech, Secretary, and Dr. C. S. Christie.

The following letter from Dr. Norman S. Garrison was presented: "I hereby tender my resignation as a member of the Committee on Public Health Clinics. I find myself, unfortunately, unable to devote to it the proper time and consideration such membership implies." It was voted to accept with regrets Dr. Garrison's resignation from this committee. Dr. Henri Gauthier was appointed in Dr. Garrison's place.

A letter from Dr. J. W. Helfrich, Westerly, protesting the proposed installation of a health unit in Washington County was presented. The plan proposes a full time health officer with nurses under his direction. It was voted that the matter be referred to the Committee on Medical Economics with the suggestion that they confer with the State Commissioner of Health for further information on the matter.

A letter from the Women's Auxiliary to the A. M. A. requesting a place on the program of the March meeting for the purpose of urging the organization of a branch in Rhode Island was presented by the Treasurer. In view of the fact that the Committee on Scientific Program have already filled the program for that meeting it was voted to table the request.

Adjourned.

Respectfully submitted,

J. W. LEECH, M.D.,  
Secretary.

#### PROVIDENCE MEDICAL ASSOCIATION

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. William S. Streker, Monday evening, February 3, 1936, at 8:35 o'clock.

The minutes of the last meeting were read and approved.

The Standing Committee having approved their applications the following were elected to membership:

Francis L. Burns  
Seebert J. Goldowsky

The following obituaries were read—on Dr. Rufus Carver by Dr. H. G. Partridge; on Dr. Horace Williams by Dr. Harvey E. Wellman; on Dr. Franklin P. Capron by Dr. Herman Pitts. It was voted to spread these on the records and to send copies to the families.

Dr. Arthur T. Jones read a letter from the American Foundation for Studies in Government in which the opinion and feeling of physicians are sought in regard to economic and social questions relating to the practice of medicine. A show of hands revealed that twelve of the members had received this letter, but that only two had answered it. Dr. Pitts stated that it was his intention to answer it as soon as he could find time. The President read a letter from Dr. Leland of the Bureau of Economics of the American Medical Association indicating that this is apparently a serious and sincere attempt to get the view point of physicians. The President, Dr. Streker, stated that the members should grasp this opportunity to put forward their ideas on these subjects.

The first paper of the evening was given by Dr. Soma Weiss, Associate Professor of Medicine, Harvard Medical School, and was entitled "The Clinical Significance and Management of Syncope." Dr. Weiss first gave a classification of various types of syncope, such as the vaso-vagal type seen in convalescence, carotid sinus reflex, vago-vagal (Stokes-Adams), pleural, pericardial and peritoneal shock, syncope from vaso-motor stimulation (e.g. cocaine) Adams-Stokes of non-reflex origin, syncope with tachycardia, syncope anginosa, syncope of congestive failure, of postural hypotension, of cerebral engorgement, of pulmonary engorgement and with dissecting aneurysm, Nothnagel and Gower's syndrome. Dr. Weiss then discussed examples and manifestations of main types, and concluded with discussion of differential diagnosis between syncope and epilepsy, an important



distinction since syncope is common and curable and epilepsy is common and not curable.

The paper was discussed by Dr. Henry L. C. Weyler and Dr. Jerome McCaffry.

The second paper of the evening was read by Dr. Russell S. Bray and was entitled "Non-Tropical Sprue: a clinical report." There were four cases presented. Important symptomatic features were—chronic diarrhea, loss of weight and strength, edema of ankles, anorexia, and meteorism. Tetanic manifestations occurred in two patients. Glossitis in three patients. Each patient presented a long history: that is, symptoms of one kind or another had been present for many years. Laboratory findings: Persistent fat in stools. Achlorhydria in three patients. Macrocytic anemia in three patients. Low serum protein in all patients. Normal blood sugar. Low blood calcium in three patients. Normal X-ray (G.I.) findings. No osteoporosis. Course of illness—Three patients succumbed to the disease. In the living patient the tongue became normal, free HCL appeared. Blood picture remained practically unchanged. Steatorrhea continues. Excellent symptomatic results. Treatment: Many remedies tried. Intensive liver therapy failed to produce the remarkable results reported by other investigators. Cause: Unknown etiology, but much evidence to support the idea of a deficiency state. Also a question of whether the deficiency state is actually secondary to the primary disease (disturbed absorption of fat).

The paper was discussed by Drs. Francis Chafee, H. A. Lawson, Ira Nichols, F. B. Cutts, Egoville and Bowman.

The meeting adjourned at 10:35 P. M. Attendance 178. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON,  
*Secretary.*

The Providence Medical Association held nine meetings during the year 1935 with a total attendance of 1519, which is 207 more than last year. The constantly increasing attendance at meetings has been striking for six years. Fifteen years ago the average attendance was 77 and it stayed about here till the depression was a year old when it suddenly began to grow and this year it has been 169. And this cannot be attributed to the size of the membership which has grown from 328 to 498, about 50 per cent, the attendance increase being about 120 per cent. The collations have kept at their old time level and probably a thirst for

knowledge and a hunger for food have both been augmented since 1928.

Eleven papers were read by members and ten by guests and the discussions were participated in by twenty-five members and seven guests.

Only one case was presented by a member.

The following were elected to membership: Elizabeth H. Sumberg, Elihu Saklad, George R. Mankis, Joseph C. Kent, Richard E. Allen, George E. Reynolds, Margaret B. Ross, Richard S. Arlen, Mark A. Yessian, George J. Dwyer, Edward J. West, Bruno G. DeFusco, Mario L. Palmieri, Americo Del Selva, Walter S. Jones, Dimetra Tsina-Elia, Vincent T. A. Bianchini, Mary Corcione, Joseph C. Flynn, Harold F. Harrington, Walter E. Hayes, Howard G. Laskey, Samuel Pritzker, Rodrigo P. DaC. Rego, Michael A. Tarro, Frederick A. Webster, Daniel D. Young, Reginald A. Allen, Ernest D. Thompson, Clara Loitman-Smith, Bernard C. Wise, James R. McKendry, Charles P. Fitzpatrick, John C. Ham.

The following were dropped for non-payment of dues: George W. Burton, Rudolph O. Fager, John F. Oslin, Patrick A. Lynam, William A. Stoops.

The Association lost this year by death: Pasquale Conca, S. Newell Smith, Oscar M. Unger, A. Arlington Fisher, Clifford H. Griffin, John W. Keefe, Francis J. Higgins, Horace N. Williams, Franklin P. Capron, B. J. Lillibridge, Rufus Herbert Carver.

During the year the Association appropriated a large amount of money for improvements in the meeting place and the delightful aspect of this room is sufficient testimony to the thoughtful work done by the committee in charge.

At the April meeting an amendment to Article VII of the By-Laws was voted and to deal with this a permanent committee on Ethics and Department was appointed.

The Standing Committee of the Providence Medical Association held nine meetings during the year 1935. Thirty-one applications for membership were approved.

#### ANNUAL REPORT OF TREASURER — 1935

Donation, R. I. Medical Society.....	\$450.00
Collations .....	600.00
MEDICAL JOURNALS .....	248.25
Binding JOURNALS .....	249.25
General Expenses .....	363.36
Secretary to Treasurer.....	150.00
Repairs in Hall.....	2,955.58
	\$5,016.44
Cash on Hand January 1, 1936.....	\$1,423.37

## ANNUAL REPORT OF TREASURER — 1935

Cash on Hand January 1, 1935.....	\$2,228.69
Checks not cashed December, 1934.....	378.85
	1,849.84
Annual Dues .....	2,239.84
Transferred from Participation Acct.	2,255.06
Checks not cashed December, 1935.....	95.25
	6,439.99
Federal tax on checks December, 1934	.18
	\$6,439.81

PETER PINEO CHASE,  
*Secretary.*

## PAWTUCKET MEDICAL ASSOCIATION

The regular meeting of the Pawtucket Medical Association was held at the Memorial Hospital, Nurses' Auditorium, on February 20, 1936, the President, Dr. W. Dufresne, presiding.

On the recommendation of the Standing Committee and the majority vote of the members present at the meeting an amendment to the constitution was made which automatically makes each new member of the Pawtucket Medical Association a member of the State Medical Association, and taxes due the State Medical Association are collectible by the Treasurer of the district organization.

Routine business was conducted. Dr. Eugene Hagan was elected an associate member. The most interesting paper of the year was presented by Dr. M. Saklad, "Important Aspects of Anaesthesia." He explained the use of cyclopropane in anaesthesia, hypnotics in local anaesthesia, and the uses of helium gas in asthma attacks and in new born infants. The paper was enthusiastically received.

Announcement was made of the formation of the Caduceus Club in Pawtucket and limited to medical practitioners of Pawtucket only.

THAD A. KROLICKI,  
*Secretary.*

## IMPORTANT NOTICE

The following letter from the Department of Commerce at Washington, D. C., has been received

by the Secretary of the Rhode Island Medical Society:

## DEPARTMENT OF COMMERCE

BUREAU OF FOREIGN AND DOMESTIC COMMERCE  
WASHINGTON

March 1, 1936.

DR. J. W. LEECH, *Secretary,*  
Rhode Island Medical Society,  
167 Angell Street,  
Providence, Rhode Island.

Dear Doctor:

We are preparing to estimate the national income for the year 1935. In this connection we need estimates of the percentage change from 1934 to 1935 in the average net income of all physicians and surgeons engaged in private practice. We would greatly appreciate an expression of your opinion as to whether the average net income of all physicians and surgeons engaged in private practice in your State increased or decreased from 1934 to 1935, or whether it remained the same.

The returns to the questionnaire sent to physicians and surgeons covering the year 1934 showed that their average net income for the nation was slightly over \$3,500 for that year. This information may be of some assistance to you in arriving at your estimate of the percentage change which we are requesting.

We are sending this letter to you in duplicate, and you may check off your estimate on the diagram given below and return one copy to us as soon as possible. For your convenience in replying we are enclosing an official return envelope which requires no postage. Your reply will be confidential and we assure you that your opinion will be of material assistance to us.

CHANGE IN AVERAGE NET INCOME OF PHYSICIANS  
AND SURGEONS FROM 1934 TO 1935

	5%	10%	15%	20%	25%	No Change
Increase .....	.....	.....	.....	.....	.....	.....
Decrease .....	.....	.....	.....	.....	.....	.....

Very truly yours,

WALTER L. SLIFER,  
*Economic Analyst,*  
*Division of Economic Research*

In the hope that publication and dissemination of the fact that physicians' incomes have suffered a marked decrease during the depression may have some effect toward stilling the clamor about the high costs of medical care, I urge the members of the Rhode Island Medical Society to send me anonymously a statement of the percentage of change in their income of 1935 as compared with that of 1934.

This information, anonymous and confidential, will be forwarded to the Department of Commerce.

Thanking you, I am

Yours truly,

J. W. LEECH, M.D.,  
*Secretary*

## ANNOUNCEMENTS

### RHODE ISLAND COMMITTEE ON FRACTURES

The Rhode Island Committee of the New England Regional Committee on Fractures of the American College of Surgeons has been organized as follows: Dr. Roland Hammond, Chairman; Dr. Murray S. Danforth and Dr. Peter Pineo Chase representing the Rhode Island Hospital; Dr. William A. Horan, St. Joseph's Hospital; Dr. S. G. Lenzner, Miriam Hospital; Dr. Henry McCusker, Homeopathic Hospital; Dr. Herbert E. Harris, Memorial Hospital; Dr. G. G. Dupre, Woonsocket Hospital; Dr. William A. Stoops, Newport Hospital; Dr. John P. Jones, South County Hospital; and Dr. John W. Helfrich, Westerly Hospital.

The purpose of this committee is largely educational and practical, and it aims to bring new and adequate methods of fracture treatment to all doctors in the state who may be interested.

A Saturday clinic will be held early in April at the Boston City Hospital and Massachusetts General Hospital to which this committee will be invited and will be given a broad clinic on up-to-date methods of treatment of fractures.

### REPORT OF COMMITTEE OF THE BLOOD TRANSFUSION BUREAU

January 1, 1936

Blood Transfusion Bureau has now been in operation for ten months. A total of 46 transfusions have been arranged.

From the Charity Fund of \$2,000, \$135 has been disbursed in payment, in whole or in part, for ten transfusions.

Income from fees is \$62.50, Expenses were \$22.05, leaving a profit of \$40.45.

Respectfully submitted,

*For the Committee,*

(Signed) FRANCIS H. CHAFEE,  
*Chairman and Treasurer.*

### F. E. R. A.

#### REPORT

January 6, 1936

The arrangement for the care of the sick on relief was recognized as an emergency temporary measure. The rules and regulations to be followed were dictated by the Federal Emergency Relief Administration. With these regulations as a guide the committee formulated a plan by which services

were rendered at reduced fees. In the interest of expediency it was necessary to accept some arbitrary regulations.

The following figures indicate the scope of the work.

The Medical Unemployment Relief program began operating in March, 1934, and the first checks were sent out in May, 1934, to 60 physicians amounting to \$622.50. Up to December 1, 1935, a total of \$110,183.43 was paid to 316 physicians. The largest amount paid in any one month was \$9,242.50 to 169 physicians in February, 1935. The largest number of physicians doing this work in any one month was 186 in October, 1935.

ELIHU SAKLAD,  
*Secretary.*

## OBITUARY

### DR. JAMES V. NIGRELLI

Dr. James V. Nigrelli died at the South County Hospital, August 10, 1935. The cause of death was pulmonary embolism, a terminal process in a streptococcic septicemia. He was born at Westerly, R. I., the son of Rosario and Domenica Nigrelli, on November 12, 1898. Educated in the public schools, he entered Cornell Medical School, leaving at the outbreak of the World War to join the U. S. Marines. At the close of the war he played professional baseball, basketball, and football for several years, earning a high reputation by his ability and good sportsmanship. In 1927 he resumed the study of medicine at Tufts, graduating in 1932. After an internship at the Rhode Island and Providence Lying-In Hospitals, he returned to Peace Dale to practice medicine, and at the time of his death he was Town Physician and a member of the staff of the South County Hospital.

His life was an unusually sad illustration of the frequent futility of human effort. A long preparation, an excellent training, a host of friends, a record for cleanness and ability, an engaging personality, a love for his work and a start that indicated that he was to go far; then an infection incurred in line of duty and a warm vital character snuffed out almost before his career had begun.

DR. H. B. POTTER  
DR. G. P. JONES

## COMMENTS UPON MEDICAL TOPICS

By MALFORD W. THEWLIS, M.D.

In giving thyroid extract after middle age, it is much safer to begin with small doses.

\* \* \*

*Early Diagnosis of Syphilis.* It is vital to detect syphilis before it becomes seropositive. The results of treatment are better and the cost of treatment to the patient is materially reduced. Special capillary tube outfits should always be on hand to collect serum from the suspected chancre, so that the specimen can be quickly transmitted to a laboratory for dark field studies.

\* \* \*

*Myxedema.* A basal metabolic rate as low as minus 40 may not be due to thyroid disturbance, according to Means and Lerman, *Arch. Int. Med.*, 1: 1, 1935. The authors give a chart showing that the zone of no symptoms of hypothyroidism is up to minus 20. From minus 20 to minus 30 is the zone of slight symptoms and from minus 30 to minus 50 is the zone of complete myxedema. While the diagnosis of myxedema should be easy, it is often missed. Of wrong diagnoses, anemia is first, Bright's disease, second; pelvic tumor (due to menorrhagia). (It is not uncommon to find that myxedematous patients are submitted to a hysterectomy when the menorrhagia is due myxedema. We must exercise care for these patients are sometimes bad operative risks—the ones who die on the table.—T.)

\* \* \*

*Streptococcic Food Poisoning.* Jordan and Burrows, *The Jour. of Infec. Dis.*, 3: 363, 1934, show that streptococci can cause food poisoning of the same general character as that caused by staphylococci. Cream pie was found infected with a green-producing streptococcus and tests of freshly isolated green-producing streptococci from other sources (one from an infected tooth and one from feces) also gave filtrates possessed of enterotoxic properties.

\* \* \*

*Spinal Fluid Sugar Determinations in Experimental Animals.* Davis and Brown, *J. Lab. and Clin. Med.*, 10: 1049, 1934, show that glucose injected intramuscularly during hypoglycemia, enters the spinal fluid very rapidly in the experimental animal. Intra-spinal glucose injections should be resorted to in the hypoglycemic diabetic who does not respond to intravenous glucose injections.

*Death Following Acute Bismuth Intoxication.* Cinani, *Dermosiflografo*, Torino, 10: 201: 1935. The author cites a case of death following bismuth administration. Most of the fatal cases are due to aggravation of affections that already existed and for this reason it is highly important to make a careful examination of the patient before giving bismuth. Most of the serious intoxications seem to have been caused by iodobismuthate of quinine. (Many keen observers find this preparation the best. Almost any drug may cause death, under the right conditions. In injecting bismuth, or any other drug deep into the muscles, it is necessary to make certain that a vein has not been punctured. If there is no blood withdrawn into the syringe it is safe to proceed. Heavy metals injected in veins may cause serious damage.—M. W. T.)

\* \* \*

*Nasal Ionization by a New Simplified Technic.* Cuttle, *Arch. Phys. Therapy*, 16: 405, 1935, gives a new method for the application of zinc ionization for allergic rhinitis.

\* \* \*

*Coronary Occlusion in Community Practice* Halbersleben, *N. E. J. of Med.*, 213: 403, 1935 concludes that diagnosis and treatment can in most cases be carried out satisfactorily in the home, relieving the burden on hospitals. The diagnosis can be made at the bedside with the aid of leucocyte counts at the physician's office. Other members of the family, or a nurse, can give closer attention to the patient than would be given in a hospital, unless special nurses are provided. (Portable apparatus will diagnose the condition very quickly and an experienced cardiologist will easily map out the course of treatment for the general practitioner.—M. W. T.)

\* \* \*

*X-ray Diagnosis of Chronic Appendicitis.* According to Scholz, *Am. Jour. Roent.*, 31: 813, 1934, the roentgen diagnosis of appendicitis is based upon one single sign—local tenderness on palpation over the visualized appendix region. All the other so-called roentgen signs are of no diagnostic value. Scholtz further states that practically every adult appendix shows microscopic and anatomical changes and these changes cannot be taken as a reliable criterion for the correctness of the diagnosis of chronic appendicitis.